



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

TRINITY MEDICAL CENTER  
C/o LAW OFFICES OF P. MATTHEW O'NEIL  
6514 McNEIL DRIVE, BLDG 2 – SUITE 201  
AUSTIN TX 78729

#### **Carrier's Austin Representative Box**

Number 01

#### **MFDR Date Received**

March 13, 2007

#### **Respondent Name**

LIBERTY MUTUAL INSURANCE CO

#### **MFDR Tracking Number**

M4-07-4267-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary taken from the Table of Disputed Services:** "Total charges exceed Stop Loss Threshold of \$40K therefore Stop Loss reimbursement is warranted."

**Amount in Dispute:** \$57,019.28

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "Updated EOP with additional payment."

**Response submitted by:** Liberty Mutual Insurance

**Respondent's Supplemental Response:** "...Please note: since the initial filing of the DWC-60 form, Liberty has issued addition [sic] payment to the Provider in the amount of \$46,647.30. A copy of the EOB, dated July 30, 2012, is included with this filing. Requestor has failed to meet the Austin Third Court of Appeals' mandate that, to qualify for reimbursement under the Stop-Loss Exception...a hospital must demonstrate two things: the services it provided during the admission were unusually costly and unusually extensive, and its total audited charges exceeded \$40,000...Respondent's review of the record demonstrates no support for unusually extensive services.....The operative report specifically notes no intraoperative complications and the post-operative progress notes the Claimant's condition to be stable. Requestor also relies upon the amount of its billed charges, arguing that as the amount it billed exceeds \$40,000, it automatically qualifies for payment per the Stop-Loss Exception...As with the unusually extensive prong, the Hospital bears the burden of proof to demonstrate that the services it provided are unusually costly...Hanna & Plaut, L.L.P., represents Liberty Mutual...in this matter..."

**Respondent's Additional Supplemental Response:** " Because Requestor has not met its burden of demonstrating unusually extensive services, and the documentation adduced thus far fails to provide any rationale for the Requestor's qualification for payment under the Stop-Loss Exception, Respondent appropriately issued payment per the standard Texas surgical *per diem* rate..."

**Supplemental Responses Submitted by:** Hanna & Plaut, LLP

## SUMMARY OF FINDINGS

| Disputed Dates          | Disputed Services           | Amount In Dispute | Amount Due |
|-------------------------|-----------------------------|-------------------|------------|
| July 11through 14, 2006 | Inpatient Hospital Services | \$57,019.28       | \$0.00     |

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.305, 31 *Texas Register* 10314, applicable to requests filed on or after December 31, 2006, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 Texas Register 6264 effective August 1, 1997, applicable to the disputed date of admission sets out the fee guidelines for inpatient services rendered in an acute care hospital.
  - Effective July 13, 2008, the Division's rule at former 28 Tex. Admin. Code § 134.401 was repealed. The repeal adoption preamble specified, in pertinent part: "Section 134.401 will continue to apply to reimbursements related to admissions prior to March 1, 2008." 33 TexReg 5319, 5220 (July 4, 2008).
  - Former 28 Tex. Admin. Code § 134.401(a) (1) specified, in pertinent part: "This guideline shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the Effective Date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act." 22 TexReg 6264, 6306 (July 4, 1997).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of Benefits
  - Z612/P303(45) – this service was reviewed in accordance with your contract with First Health
  - Z585 (W10) - the charge for this procedure exceeds fair and reasonable
  - Z710(W1) – the charge for this procedure exceeds the fee schedule allowance
  - Z695(W1) – the charges for this hospitalization have been reduced based on the fee schedule allowance

### Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

### Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original medical dispute resolution (MDR) submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November

13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection.” 28 Texas Administrative Code §134.401(c) (6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c) (6) (A) (i) states “to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “Audited charges are those charges which remain after a bill review by the insurance carrier has been performed.” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c) (6) (A) (v); therefore the audited charges equal \$98,423.75. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its position statement presumes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services.” The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 Texas Administrative Code §134.401(c) (6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor failed to demonstrate that the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 Texas Administrative Code §134.401(c) (6).
4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that “The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
  - (i) a rate for workers’ compensation cases pre-negotiated between the carrier and the hospital;
  - (ii) the hospital’s usual and customary charges; and
  - (iii) reimbursement as set out in section (c) of this section for that admission
- In regards to a pre-negotiated rate, the services in dispute were reduced in part with the explanation “Z612 – this bill was reviewed in accordance with your contract with First Health.” Coventry Health Care submitted a copy of a contract between Texas Affordable Health Care Concepts (AHCC) and Trinity Medical Center; however, no documentation was provided to support that a reimbursement rate was negotiated between the workers’ compensation insurance carrier LIBERTY MUTUAL INSURANCE CO and Trinity Medical Center prior to the services being rendered; therefore 28 Texas Administrative Code §134.401(b) (2) (A) (i) does not apply.

In regards to the hospital’s usual and customary charges in this case, review of the medical bill finds that the health care provider’s usual and customary charges equal \$98,423.75.

In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1), titled Standard Per Diem Amount, and §134.401(c)(4), titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c) (4) apply only to bills that do not reach the stop-loss threshold described in subsection (c) (6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c) (3) (ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission.” The length of stay was three days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of three days results in an allowable amount of \$3,354.00.

- 28 Texas Administrative Code §134.401(c) (4) (C), states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$288.75/unit for Surgicel 4x8; \$612.50/unit for Thrombin 20000U spray kit; and \$719.75/unit for Desflurane 240ml. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, reimbursement for these items cannot be recommended.
- 28 Texas Administrative Code §134.401(c) (4) (A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

| Rev Code        | Itemized Statement Description | Cost Invoice Description  | UNITS / Cost Per Unit | Total Cost  | Cost + 10%  |
|-----------------|--------------------------------|---|-----------------------|-------------|-------------|
| 278             | Imp lumb fusion primary        | Vanguard 16mm; screw 22mm; screw 25mm; and spinal fusion stimulator (kit) | 1 @ \$12,244.00       | \$12,244.00 | \$13,468.40 |
| 278             | Bn plugs 3110                  | Implant bone plug matrix 14mm x 1mm                                       | 1 @ \$252.00          | \$252.00    | \$277.20    |
| TOTAL ALLOWABLE |                                |   |                       | \$13,745.60 |             |

The total reimbursement set out in the applicable portions of (c) results in \$3,354 + \$13,745.60, for a total of \$17,099.60.

Reimbursement for the services in dispute is therefore determined by the lesser of:

| §134.401(b)(2)(A) | Finding        |
|-------------------|----------------|
| (i)               | Not Applicable |
| (ii)              | \$98,423.75    |
| (iii)             | \$17,099.60    |

The division concludes that application of the standard per diem amount and the additional reimbursements under §134.401(c) (4) represents the lesser of the three considerations. The respondent issued payment in the amount of \$46,647.30. Based upon the documentation submitted, no additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the division concludes that the services in dispute are not eligible for the stop-loss method of reimbursement, that a pre-negotiated rate does not apply, and that application of 28 Texas Administrative Code §134.401(c) (1) titled *Standard Per Diem Amount* and §134.401(c) (4) titled *Additional Reimbursements*, results in the total allowable reimbursement. Based upon the documentation submitted, the requestor's Table of Disputed Services, and reimbursement made by the respondent, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution

\_\_\_\_\_  
April , 2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**